Christopher
TAYLOR MFT
LIC# 79581
916.873.6434
CHRISTAYLORMFT@GMAIL.COM
CHRISTAYLORMFT.COM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at 916-873-6434
.
If you have any questions about my Notice of Privacy Practices, please contact me at: 916-873-6434.

I acknowledge receipt of the Notice of Privacy Practices of Christopher E. Taylor, LMFT.

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

My signature below indicates I declined a copy of the Notice of Privacy Practices although it was offered to me.

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including

_____.

However, because of _____
I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____ Date: _____